While I personally strive for increased flexibility and creativity in my own work, I now look to the future, and wonder how what lies ahead in our understanding of this magnificent modality in our therapy. In the final analysis, however, it is the unique needs of our patients that matter most. We need to maintain our freedom to be ourselves while we balance the demands of the structures of our disciplines to well serve those who seek our care.

In closing, I thank the members of the International Society of Hypnosis. I will never forget the privilege you granted me to serve our Society these many years. It has forever shaped my life.

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The application of hypnosis to children and adolescents traumatized by war

Julie H. Linden

Hypnosis has been applied to many areas of trauma treatment. This paper will explore the utilization of hypnosis and hypnoidal techniques with children and adolescents traumatized by war. Attention will be given to cross cultural issues as they interact with and affect adjustment and psychological healing experienced by refugee, "refugee-like" and orphaned populations.

African storytellers have a venerable tradition of conveying through metaphor images capable of painting pictures for the listener (Godwin, 2000). An example of this is a particularly poignant African saying "When elephants fight, it is the grass that suffers" (Reidesser, Walter, Adam & Verderber, 1996, p.13), a reminder of the helplessness of the young (Brooks, 1996) in the face of massive, destructive forces abusing power. We do not have words large enough, intense enough, emotional enough to describe the horrors of war. This may be the reason that hypnosis became my treatment of choice in working with victims of war. Hypnosis permits us to bypass the logical conscious brain and go directly to that feeling, creative, pictorial brain where most traumatic memories are lodged.

There are many events that can be considered traumatic. Natural disasters, physical and sexual abuse, chronic illness, death of a loved one are a few. We have learned that trauma at the hands of a fellow human is far worse than trauma from nature. But war may be the worst of all traumas.

War is a traumatic event that, more than causing physiological and psychological pain, destroys the social structure. It takes away the very communal structures that the growing child requires for socialization, for identity formation. War removes the traditional support systems which stimulate and sustain resilience in children, from where they draw their coping mechanisms (Dyregrov, Gupta, Gjestad & Mukanheliet, 2000).

The psychic traumatization of children and adolescents from exposure to war is of great concern (Pynoos, 1994; Apfel & Simon, 1996; Reidesser, et al, 1996; Northwood, 1998; Abu-Saba, 1999) because we have entered an era in which civilians are increasingly the targets of war (Garbarino, Kostelny & Dubrow, 1991; Husain, Nair, Hol-

comb, Reid, Vargas, & Nair, 1998). Kapor-Stanulovic (1999, p.1021) notes that the "proportion of war victims who are civilians has increased - from 5% at the turn of the century - to more than 90% in the wars of the 1990s. More than half are children."

I became interested in traumatization from war when a large group of students from Bosnia was brought to my hometown during the war in the Balkans. That was in 1994. For the past 6 years, I have worked with those students, read everything I could find on the treatment of children of war, traveled to and interviewed other mental health workers from places of war, and discovered both how little and how much we in the mental health field know about this form of trauma (Bloom & Reichert, 1998). I was dismayed to discover how few clinicians have applied hypnosis to the treatment of trauma from war in spite of copious literature supporting the use of hypnosis (Herman, 1992; van der Hart, Steele, Boon, & Brown, 1993; Watkins, 2000). Most often associated with combat fatigue or war neuroses of soldiers, hypnosis has experienced a spotty history of acceptance in the past century for treatment of war trauma. The hypnotic work of Dr. W.H.R. Rivers, British neurologist and social anthropologist, in uncovering and treating the soldiers trauma from war experiences has been popularized in a trilogy of books about World War I, written by Pat Barker (1991, 1993, 1995).

Cardena (2000, p.226) suggests one reason for the infrequent use of hypnosis in treatment of trauma may be the "lack of systematic research on hypnotic techniques for trauma [...] especially troubling when meta-analysis of various clinical conditions have indicated that adding hypnosis to cognitive-behavioral or psychodynamic interventions increases their efficacy."

What makes hypnosis suitable? The relationship between war and PTSD symptoms is well established (Eth & Pynoos,1984; van der Kolk, 1987; Herman, 1992). We know these symptoms to be like cosmic disturbances in the nervous system including distortions in cognition, hyper and hypo arousal of the body's biochemistry and motor functioning that occur both day and night, in our conscious life as well as in our state of sleep.

A survey organized by Dr. Stevan Weine (Weine & Pavkovic, 1995), psychiatric consultant to the FOR Bosnian Student Project, and Director of the Project on Genocide, Psychiatry and Witnessing at the University of Illinois at Chicago gathered information on the types of traumatic experiences and PTSD symptoms 38 Bosnian students reported. This data is important since it offers information on adolescents, rather than the usual adult populations studied. Table 1 shows the type and frequency of PTSD symptoms reported by adolescent group members. (These students were 68% female, 32% male. They had a mean age of 19.7 years. 92% were full time students, with 16% in high school, 63% in college, and 3% in graduate school. 50% were living with host families, 37% in a dorm, and the remaining 13% had other living arrangements. This group was roughly equivalent to the group of Bosnian students I worked with in Philadelphia.)

While no formal survey was done of the Philadelphia group, the types of traumatic

Tab. 1: Type and Frequency of PTSD Symptoms

1. Being upset when reminded of war experiences (92%)*
2. Having intrusive memories (89%)*
3. Being watchful or on guard (84%)*
4. Avoiding thoughts of the war (81%)*
5. Having nightmares (76%)
6. Feeling cut off from others (76%)*
7. Increased startle response (71%)*
8. Decreased concentration (68%)*
9. Feeling numb (61%)*
10. Having sleep disturbance ((61%)*
11. Reactivity to war reminders (61%)*
12. Decreased interest (58%)
13. Flashbacks (58%)*
14. Avoiding war reminders (55%)*
15. Irritability (53%)*
16. Feeling future is unclear (50%)*
17. Amnesia (16%)

From Weine & Pavkovic (1995). Items with a star (*) were reported by the Philadelphia group.

experiences the survey group reported were similar to the verbal reports of the Philadelphia group. Those reported by the Philadelphia group are starred.

The presence of PTSD symptoms in victims of war makes hypnosis a particularly effective treatment modality. There are similarities in altered states of consciousness in victims of trauma and those reported by individuals in a hypnotic context. These include a narrowed focus of attention, dissociation, altered sense of time, and altered sensory perceptions (Cardena, 2000). It is my experience that the similarity in states permits the use of hypnosis to access both cognitive and somatic memory and that hypnosis is particularly flexible for working with these accessed memories because of the easy use of imagination to relax, to contain, and to distance from traumatic material. Beverly James (1989) argues that unless a child's affective state is the same way he/she felt during the initial trauma, during the time new understandings or cognitions are taught, no change in symptoms can occur. This, too, has been my experience.

Hypnosis teaches automaticity of responses (Kirsch & Lynne 1999). This allows for the teaching of an automatic relaxation response, very useful when dealing with traumatic material. Second, one can create endless containment techniques through imagery utilizing trance logic phenomenon. Containment of overwhelming affect is one of the most challenging facets of trauma work. Third, the trance state recapitulates the dissociative mechanisms utilized in the nervous system's response to trauma. And fourth, hypnosis serves as a bridge between conscious and unconscious processes, accessing pictorial and sensorial memory ubiquitous to trauma, often permitting the amelioration or rapid diminution of symptoms.

With regard to adolescent development, Harper (1999) notes there is an increase in

daydreaming, which he likens to an altered state of awareness. This results from advanced cognitive abilities of adolescence and may prime the adolescent for the use of hypnosis since it offers the adolescent "the experience of moving from one level of awareness to another" (ibid, p.52). In addition, with the emergence of adolescent egocentrism, the teen's sense of invulnerability may be utilized positively in hypnotic suggestions to foster self-efficacy (Ferren, 1999) and sense of control (Hadi & Llabre, 1998).

Peirre Janet's three stage model for the treatment of trauma includes a stabilizing phase, an uncovering phase and a reintegration phase. Hypnosis is unique in its therapeutic usefulness at each stage: relaxation in stage one, age regression and exploration of the past at stage two, and future oriented inductions for stage three.

Janet's three phase model also organizes the social, the individual, and the world under siege into a useful framework. It reminds us of the self-in-relation crucial to healing the worst aspects of trauma: the loss of faith in the future and in fellow humankind.

Details of my work with the Bosnian students are the subject of another paper, where I discuss the success of group hypnosis (Linden, 1997).

Hypnoidal techniques or hypnotic-like techniques differ from formal hypnosis in that they utilize the naturally occurring trance state and relaxation response (Linden, 1996). These trance states can be paired with suggestions just as is done in formal trance inductions, and are suitable for work with children where the imagination is more present than in adults. Children prefer action to talking. Most forms of play for children produce trance states. In fact, one function of play at a biological level is to relax and release tension. At an intrapersonal level, play may provide for mastery of conflicts through the use of symbolism and wish fulfillment. The therapeutic use of play usually refers to alone play with the therapist, using an art medium, toys or drama, storytelling through activity, make believe. Sand tray work may be so powerful because of its use of all three.

Josephine Hilgard (LeBaron & Hilgard, 1984) referred to the imaginative involvement of young children as the prototype for hypnosis. The well-timed placement of a suggestion during play can be used at any phase of treatment. This gives words to feelings, gives meaning to action, gives perspective where none existed. Much of play remains nonverbal, and the attachment of words to actions during a trance state can be positively transformational to the young mind. The astute clinician knows the negative power of suggestions given to the young child in a trance state, such as the angry words of a caregiver when the child is in a state of shock or embarrassment.

For the past two summers I have volunteered at a humanitarian children's camp in Croatia. Children from all over the Balkans, ages 6 to 14, who experienced most of their childhood as victims of war attend this camp. Many of these children have lost at least one parent during or since the war. The main goal of the camp is for the children to have fun in a safe and caring environment. Having fun means play, and there are many forms of play at this camp, each designed to be healing, to break the cycle of

trauma, to develop renewed hope in one self and humanity. Garbarino (et al, 1991) notes that humor and positive reframes are key factors in providing stability and support to traumatized youth. Camp play gave boys the chance to dress as girls, on dress-up night, identifying with their nurturing side. One young boy who had most of his ear destroyed by a shell, dressed in a long wig, covering his deformity. He strutted with new confidence that evening. On Hawaii night, the young and adolescent boys dressed as "warriors", perhaps an expression through play of their need for control over aggression.

Treating a war traumatized population has many challenges, and it is further complicated when the work is cross cultural. There are obstacles to cross cultural work that center on the social level: those of language, cultural norms and cultural identity.

The acceptance of therapy, of treatment for trauma symptoms, is hardly universal (Yehuda, 1998), and almost every intervention program begins with psychoeducation of the public about PTSD and its treatment. These programs all emphasize, in culturally relevant and acceptable language, the help available to people. This help generally is only sought after more basic needs of food and shelter have been met.

Researchers have noted the importance of instruments developed within a culture and cross validated there, although often they are not available, and must be translated (Dyregrov et al, 2000). Use of translators in therapy is cumbersome and requires specially trained translators, often unavailable in times of war. There is also the need to tend to vicarious traumatization issues with the translator or retraumatization issues if the translator was also a victim of the same war.

My work with the Bosnian adolescent students was all in English, while my work at the children's camp was through translators, themselves adult victims of war. In each of these cases hypnosis proved to be able to transcend the cultural and move us to the universal archetypes, a common language (see Table 2).

Some specific cross cultural issues that emerged in my work in the United States included culture shock, the notable differences between customs, in this case of the Balkan students and their American peers. Marsella (1994) states that in the exploration of ethnocentric issues a non-judgmental approach is essential. Because my work with the adolescents was in a group context it was rather easy to build interpersonal support systems, and to explore a variety of reactions to adjusting to a new culture (Marmar, Foy, Kagan, & Pynoos, 1994). Ego strengthening techniques further developed self-efficacy and self confidence, which enhanced coping mechanisms and resiliency.

The teenagers complained about the pace of life, the lack of social gatherings outside of school, the confusion about racial identity issues and other behaviors they related to quality of life issues. Each of the Bosnian students had been placed in a host (or foster) family, so in addition to the larger societal differences, there were also the interfamilial differences with which to adjust. The families complained, too, that students were insensitive to electric, telephone and water costs; interesting to note that these

Tab.2: A conceptual model for the stages of work and the issues addressed with children and adolescent victims of war.

Stage One: Stabilization-the self within the cultural context

- Culture Shock: Individual practical everyday matters
- Communication with family of origin
- School: comparing and contrasting
- Health: physical, emotional and assessment of PTSD symptoms, Psycho-educational material on trauma
- Building group support
- Community: peers, sports, service, religion
- Role of host parent
- Positive outlook: modeling new ideologies

Stage Two: Uncovering- the intra-psychic self

- Exploring the past
- Telling the story- war narratives
- Personal identity- family of origin and individual dynamics
- Developing awareness about need for social support (reversing collective denial)
- Skill building: increasing coping resources and strategies for symptom relief

Stage Three: Reintegration- the universal self

- Meaning making in:
  - Connection to family
  - Connection to community
  - Peer relationships
- Ethnic/cultural identity-"two me's"
- Religious identity
- Dating
- Life structure:
  - Decisions about returning home
  - Career/academic choices
- Building a vision for the future

were coveted items for the students when they first arrived from their war torn countries. A favorite topic was missed foods, made more intense by the also missed families with whom they had shared those foods. I still remember the college student who over a bowl of ice cream following an evening of psychodrama about war related experiences declared (and I paraphrase) 'ice cream is the universal food for the soul'. After that, I began to include food references in my hypnotic imagery with them.

As one would expect, school differences was a major topic of exploration, as was health both physical and emotional. And of course, these students were prematurely submerged into religious identity considerations as the "ethnic cleansing" (Riedlmayer, 1994; Weine, 1994; Sells, 1996; Weine, Becker, Vojvoda, Hodzic, Sawyer, Hyman,

Laub & McGlashan, 1998) they had been subjected to magnified all factors relating to religious identity.

We do not know what coping mechanisms lead most quickly to the resolution of PTSD symptoms or to the successful adjustment to living life for anyone coming out of war, not for adults, adolescents or children. We do know, though, that the young whose identities are incomplete and in the process of formation, when transported to a new country seem to take on a new culture, a new language, a new life style quickly, while adults are much slower to adjust. Adolescents, caught in between, express some of the greatest confusion with bi-cultural identity and integration. Bi-cultural refers to the internalization of two cultures, although bi-cultural individuals report the two internalized cultures take turns in guiding their thoughts and feelings (Hong, Morris, Chiu, & Benet-Martinez, 2000) and may not be blended. Hypnosis, when it furthers creative imagination, increases the range of possibilities from which children and adolescents may draw their futures.

We also know that some coping mechanisms work better than others. A key to development is teaching, as Garbarino and Kostleny (1996) have stated, so providing the adolescent with an opportunity to move from the role of student to that of teacher can foster resiliency and increase self-esteem. Kapur-Stanulovic (1999) entreats us to think preventively, creatively, energetically, rather than curatively about war and its young victims. With this in mind, I was able to take five of my Bosnian students to the humanitarian camp to work as counselors and translators. I hoped the experience would form a foundation in them to deter the intergenerational transmission of trauma (Bar-On, 1996). Here they were able to bridge their two cultural identities, to look ahead to the future, their own and their country's and to think about the children yet to be born, the untrampled blades of grass in need of our protection.

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